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ABSTRACT

Mentally retarded people may be particularly vulnerable to depression and related emotional disturbances due to limited social skills, lack of friends, and negative self-esteem. A therapy group for depressed retarded clients provided an opportunity to collect information about depression in retarded individuals and to evaluate various treatment techniques in a group format. Mildly retarded adults, two males and two females, attended the 30 weekly sessions involving open-ended discussions and behavioral techniques such as modeling, role playing, behavioral rehearsal, and selective reinforcement. To assess the effectiveness of the group, clients were given the Zung Depression Scale before and after treatment and evaluated on a behavior checklist by a close acquaintance during a 1-week period at mid-group and at the end of treatment. Therapists also made weekly observations. Major concerns expressed by the group were a desire for greater independence, fear of harm, and failure to distinguish between realistic and unrealistic hopes. The social component was an especially important aspect of therapy, and all clients showed at least some improvement. (JAC)

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Depression and Mental Retardation

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Mentally retarded people may be particularly vulnerable to depression and related emotional disturbances. Retarded people often have limited social skills and few friends, and their repeated experiences of failure in social situations result in negative self-evaluation. The combination of poor social functioning, low self-esteem, and limited problem-solving ability should increase vulnerability to depression.

In a review article on depression in the mentally retarded, Matson (1982a) cites a number of surveys which suggest that depression occurs in that population at a high rate. The experience of the Institute for the Study of Developmental Disabilities (ISDD) clinic during the past two years corroborates these findings. During the first year of the clinic's operation, almost 14% of our clients presented with depression as their primary problem. In the clinic's second year, the number of adult depressed clients rose to 27%. These percentages are comparable to the range reported in non-retarded populations (Kendall and Hollon, 1979; Matson, 1982b). The symptoms of the retarded clients are similar to those found in non-retarded depressed persons, including crying, hopelessness, low level of activity, sleep disturbance, and poor self-esteem.

The state of knowledge about depression in mentally retarded people is such that descriptive studies are needed to suggest treatment approaches and issues for more rigorous research. In the fall of 1981, the ISDD clinic planned a therapy group for depressed clients. An important consideration in the planning for this group was the opportunity to collect information about the nature of depression in retarded people and to evaluate various treatment techniques in a group format.

The therapy group was composed of four adults, 2 males and 2 females, all functioning in the mild range of retardation and exhibiting symptoms of

depression. The age range was 26 to 41. Two co-therapists, a male and a female, led the group, which met weekly for thirty sessions. Two of the clients lived at home with parents and two lived in group residences. Two were in a sheltered workshop, one in a work activities program, and one was unemployed. Three of the clients also received individual counseling during the period that the group met. All the clients had been referred to the clinic by outside agencies who requested treatment for the individual's emotional disturbance.

The format of the group, which was determined by the therapists, included open-ended discussions and behavior techniques such as modeling, role playing, behavior rehearsal, and selective reinforcement. The content of the group sessions was determined, for the most part, by the clients, who were invited to raise issues of importance to them. Clients were also asked to complete daily mood check forms (circling a face which reflected their mood) as homework and to submit them weekly.

To assess the effectiveness of the group, two types of formal data were collected. Clients were given the Zung Depression Scale (Zung, 1965) at the beginning and the end of treatment. The scale is usually self-administered but we read the questions to clients and recorded their responses. With the clients' permission, a person who knew the client fairly well (not a relative) completed a checklist about the client's behavior during a one-week period at mid-group and again at the end of treatment.

The most important and useful data came directly from the group sessions. Weekly written observations were made by each of the co-therapists. In addition, approximately one-third of the sessions were videotaped, allowing for repeated scrutiny of what had occurred in the taped sessions. It

became obvious that the therapy sessions revolved around several dominant themes which the clients kept returning to. On the basis of these data, it is possible to describe several salient aspects of depression in our retarded clients.

Perhaps the major concern expressed by group members was a desire for greater independence. All the clients felt that they were unable to control the course of their lives. They were so accustomed to having others (parents, caretakers) planning for them and monitoring their behavior that they had great difficulty accepting responsibility for their failures or successes. All the clients agreed that they had been overprotected by their families and then pushed hard to be more independent. The conflict over dependence on others resulted in feelings of hopelessness about making changes for the better and in resentment toward those who seemed to be controlling their lives. An example of this problem was one group member's belief that it was impossible for her to get a decent job because employers were all liars who discriminated against her and made impossible demands. It is interesting that the problem of getting a better job surfaced quite early in the group and became a recurring theme. The job issue seemed to be a metaphor for the general problem of needing more independence and more control over what happened to them.

The therapists responded to the independence issue with the introduction of problem-solving strategies and assertiveness training. Clients were first invited to formulate goals (e.g., move out from parental home, become competetively employed). Clients then discussed the obstacles they feared would impede their progress. Eventually, concrete strategies for reading the goals were developed and, if appropriate, practiced in the group.

The therapists introduced the importance of being assertive by describing three basic ways to behave: shy, mad, or sticking up for yourself. This became a group convention or formula which the clients began to be able to apply with some facility to specific issues raised in the sessions.

Another salient aspect of our clients' depression was a generalized apprehension of being preyed upon or harmed by others. This seemed to be related to their experiences of being managed by many infantilizing caretakers. People who once appeared to be benevolent were now experienced as obstructive or intrusive. A part of their apprehension seemed to originate in the clients' realistic appraisal of the dangers of living in a large city, especially the threat of physical attack. In addition, all the clients had at some time been teased or ridiculed for being different or slow. Clients expressed great anger and indignation at such treatment, particularly when the offender was a relative.

Another thematic problem which emerged in the group was the failure of clients to distinguish between realistic and unrealistic hopes. As clients moved from a stance of hopelessness to one of anticipated action, they frequently described grandiose plans which were far beyond their abilities. For example, one group member hoped to go to college and study musical composition. Another group member said that he would never be happy unless he could drive a car and have all the things his younger brothers had. The therapists tried to help clients to explore what these goals really meant to them and to consider less ambitious goals which would also satisfy their needs for accomplishment and recognition. An issue related to unrealistic hopes was the clients' difficulty in breaking down realistic general goals into manageable subgoals.

It is worth noting that the group developed in ways very similar to a therapy group of non-retarded people (see Yalom, 1975). The group passed through typical developmental stages, such as finding common ground, building cohesiveness, and sharing increasingly intimate information. In general, group members experienced great relief in finding that others had problems similar to their own, and advice was traded back and forth with regularity. On a number of occasions, the clients were asked what they were getting from the group. Some typical answers were that it was a place to meet nice people, a chance to tell others what they felt, an opportunity to speak up and be listened to, and a place where one could be understood.

In evaluating the group's effectiveness, we compared data from the assessment measures, looked at clients' current situations, and solicited comments from people who knew the clients. The results were mixed. According to scores of the Zung Depression Scale, two of the clients improved and two showed more depression. On the behavior checklists sent to people familiar with the clients, we had data for three of the four clients. All three showed improvement, that is, less evidence of depressed behavior. No statistical analysis was attempted because of the small number of clients. Daily mood check forms were returned too erratically to allow for any systematic analysis. They were useful on occasion, as the impetus for discussing a group member's moods during a particular week. Clearly, we need to work on better assessment measures for all varieties of psychopathology in mentally retarded populations, including depression. By the report of others involved with the clients, all the group members were less depressed and had made progress toward

improving their situations. The two clients in sheltered workshops were preparing to move into transitional employment programs and were living more harmoniously in their group residences. One of these clients reported that his residential counselor told him that the group had "turned him around" and helped him to overcome his self-defeating behavior patterns. The client in a work activities program had begun to address the fundamental problem he had with separating from his parents, a necessary step toward greater independence. The unemployed group member, who also had great difficulty in communication, was doing better in her twice-weekly recreation group and had begun speaking more spontaneously both in the group and at home. All the group members reported that the social aspects of the group had been particularly helpful and enjoyable. This is an important point because the clients all initially had deficient social skills and few friends. Our clients did form friendly relationships with one another and became increasingly appropriate in their interactions. By the end of the group, clients were able to conduct the sessions with minimal input from the therapists. These sorts of informal assessments indicate that the group experience was helpful to our depressed clients. A follow-up of the clients is planned at 3 months, 6 months, and one year after the group's end.

In summary, we learned that depression in the mentally retarded, while similar to depression in a normal population, may have characteristic features which should be addressed in treatment. Our mentally retarded clients had special problems with issues of independence. The central concern of our clients was to be able to have more control over their lives. Related to this issue, was a generalized apprehension of being

harmed or exploited by more powerful others, including family members. In planning for the future or trying to solve current problems, our clients were likely to generate unrealistic goals or to fail to break down general goals into manageable steps. We also found that our clients had a limited capacity to enjoy themselves. A group treatment approach to depression in the mentally retarded may be especially effective because of the social component it offers, including the chance for comparison with similar others, and the opportunity for forming relationships with group members and for acquiring better social skills.

References

Hollon, S. D. and Beck, A. T. Cognitive therapy of depression, in P. C. Kendall and S. D. Hollon, Cognitive Behavioral Interventions. New York: Academic Press, 1979, 153-197.

Matson, J. L. Depression in the mentally retarded: a review. Education and Training of the Mentally Retarded, 1982 a , 17, 159-163.

Matson, J. L. The treatment of behavioral characteristics of depression in the mentally retarded. Behavior Therapy, 1982b, 13, 209-218.

Zung, W. A self rating-depression scale. Archives of General Psychiatry, 1965, 12, 63-70.